

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0025411</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Mulberry Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>P.O. Box 88, (Phy Loc: 612 E. Davie)</u> <u>Anna</u> <u>62906</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Union</u>		Officer or Administrator of Provider (Signed) <u>03/29/02</u> (Type or Print Name) <u>Richard Stroh</u> (Date)	
Telephone Number: <u>(618) 833-6012</u> Fax # <u>(618) 833-4993</u>		(Title) <u>Assistant Comptroller</u>	
IDPA ID Number: <u>37-10828260001</u>		(Signed) _____ (Date)	
Date of Initial License for Current Owners: <u>1/1/72</u>		Paid Preparer (Print Name and Title) _____	
Type of Ownership:		(Firm Name & Address) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Telephone) <u>()</u> Fax # ()	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Richard Stroh</u> Telephone Number: <u>(618) 833-5070 ext. 11</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Mulberry Manor# 0025411 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 80 Bed / 29,200 Bed Days

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	<u>80</u>	Intermediate/DD	<u>80</u>	<u>29,200</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>27,922</u>			<u>27,922</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,922</u>			<u>27,922</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.62%

D. How many bed-hold days during this year were paid by Public Aid?

96 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

N/AF. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/1/72

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 1/1/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	91,883	6,166	7,687	105,736		105,736		105,736		1
2	Food Purchase		161,279		161,279		161,279		161,279		2
3	Housekeeping	81,744	26,399	1,732	109,875		109,875	455	110,330		3
4	Laundry		12,453	218	12,671		12,671		12,671		4
5	Heat and Other Utilities			55,917	55,917		55,917	971	56,888		5
6	Maintenance	42,124	16,169	21,878	80,171		80,171	21,213	101,384		6
7	Other (specify):*										7
8	TOTAL General Services	215,751	222,466	87,432	525,649		525,649	22,639	548,288		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	131,756	21,792	21,554	175,102		175,102	4,866	179,968		10
10a	Therapy			4,475	4,475		4,475		4,475		10a
11	Activities	675,769	4,290	3,668	683,727		683,727		683,727		11
12	Social Services	105,471	2,500	15,857	123,828		123,828	(911)	122,917		12
13	Nurse Aide Training			11,495	11,495		11,495		11,495		13
14	Program Transportation			7,681	7,681		7,681		7,681		14
15	Other (specify):* Day Training Exp.			739,394	739,394		739,394	(739,394)			15
16	TOTAL Health Care and Programs	912,996	28,582	804,124	1,745,702		1,745,702	(735,439)	1,010,263		16
	C. General Administration										
17	Administrative	100,083			100,083		100,083	29,251	129,334		17
18	Directors Fees										18
19	Professional Services			124,224	124,224		124,224	(118,397)	5,827		19
20	Dues, Fees, Subscriptions & Promotions			8,739	8,739		8,739	(2,832)	5,907		20
21	Clerical & General Office Expenses		19,055	15,138	34,193		34,193	42,585	76,778		21
22	Employee Benefits & Payroll Taxes			144,262	144,262		144,262	19,124	163,386		22
23	Inservice Training & Education										23
24	Travel and Seminar							587	587		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			14,780	14,780		14,780	699	15,479		26
27	Other (specify):*										27
28	TOTAL General Administration	100,083	19,055	307,143	426,281		426,281	(28,983)	397,298		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,228,830	270,103	1,198,699	2,697,632		2,697,632	(741,783)	1,955,849		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Mulberry Manor

#0025411

Report Period Beginning:

1/1/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			20,413	20,413		20,413	13,546	33,959			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			91	91		91	(91)				32
33	Real Estate Taxes			24,816	24,816		24,816	615	25,431			33
34	Rent-Facility & Grounds							(224,926)	(224,926)			34
35	Rent-Equipment & Vehicles			244,918	244,918		244,918		244,918			35
36	Other (specify):*			194,034	194,034		194,034	(194,255)	(221)			36
37	TOTAL Ownership			484,272	484,272		484,272	(405,111)	79,161			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		1,251		1,251		1,251		1,251			41
42	Provider Participation Fee		157,146		157,146		157,146		157,146			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		158,397		158,397		158,397		158,397			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,228,830	428,500	1,682,971	3,340,301		3,340,301	(1,146,894)	2,193,407			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Mulberry Manor**# **0025411**

Report Period Beginning:

1/1/01

Ending:

12/31/01**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
NON-ALLOWABLE EXPENSES					
1	Day Care	\$ (739,394)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(773)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,241	30		9
10	Interest and Other Investment Income	(91)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,732)	36		18
19	Entertainment				19
20	Contributions	(1,067)	20		20
21	Owner or Key-Man Insurance	(246)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,788)	36		24
25	Fund Raising, Advertising and Promotional	(2,017)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(161,735)	36		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (929,602)		\$	30

OHF USE ONLY							
48		49	50	51	52		

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(215,490)		34
35	Other- Attach Schedule Pg. 5A	(1,802)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (217,292)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,146,894)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mulberry ManorID# 0025411Report Period Beginning: 1/1/01Ending: 12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Clothing	\$ (702)	12	1
2	Cigarettes	(209)	12	2
3	Misc. Employee Benefits	(891)	22	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,802)		49

Summary A

12/31/01

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/01

Ending:

12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James K. Keller	50	Pilot House	Cairo	kel-Tech Mgmt Co	Anna	Accting Services
Jo Ann Keller	50	Holly Hill	Anna	JR's Centre	Anna	Day Training
		Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	3 Houskeeping	\$	kel-Tech Mgmt. Co.	25.00%	\$ 455	\$ 455 1
2	V	5 Utilities		kel-Tech Mgmt. Co.	25.00%	971	971 2
3	V	6 Repairs & Maintenance		kel-Tech Mgmt. Co.	25.00%	2,242	2,242 3
4	V	19 Legal & Accounting		kel-Tech Mgmt. Co.	25.00%	1,603	1,603 4
5	V	20 Dues, Fees & Subscriptions		kel-Tech Mgmt. Co.	25.00%	252	252 5
6	V	21 General & Adm. Expenses		kel-Tech Mgmt. Co.	25.00%	7,358	7,358 6
7	V	22 Employee Benefits		kel-Tech Mgmt. Co.	25.00%	20,788	20,788 7
8	V	24 Staff Training		kel-Tech Mgmt. Co.	25.00%	587	587 8
9	V	26 Insurance Building & Vehicle		kel-Tech Mgmt. Co.	25.00%	945	945 9
10	V	30 Depreciation		kel-Tech Mgmt. Co.	25.00%	5,305	5,305 10
11	V	33 Real Estate Taxes		kel-Tech Mgmt. Co.	25.00%	615	615 11
12	V	34 Building Lease Pmts.		kel-Tech Mgmt. Co.	25.00%	2,975	2,975 12
13	V						
14	Total		\$			\$ 44,096	\$ * 44,096 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/01Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Wages	\$	kel-Tech Mgmt Co.	25.00%	\$ 4,866	\$ 4,866	15
16	V	17 Administrative Wages		kel-Tech Mgmt Co.	25.00%	29,251	29,251	16
17	V	21 Clerical Wages		kel-Tech Mgmt Co.	25.00%	35,227	35,227	17
18	V	6 Maintenance Wages		kel-Tech Mgmt Co.	25.00%	18,971	18,971	18
19	V	19 Professional Services	120,000	kel-Tech Mgmt Co.			(120,000)	19
20	V	34 Building Lease	240,000	J & J Partners			(240,000)	20
21	V	34 Depreciation		J & J Partners		12,099	12,099	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 360,000			\$ 100,414	\$ * (259,586)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jo Ann Keller	Owner/Administrator	Administrator	50.00	24,000	32	80.00	Adm. Wage	\$ 73,600	17-1	1
2	Diana Alley	Nursing	Program/Nursing		25,300	4	10.00	Nursing Wage	9,900	10-1	2
3	Doris Davis	Activity Director	Activities			40	100.00	Activity Wage	27,289	11-1	3
4	James K. Keller	Owner/Maintenance	Maintenance	50.00		20	50.00	Maint. Wage	13,800	6-1	4
5											5
6	kel-Tech Mgmt Co. Total Before Allocation										6
7	James A. Keller							Admin. Wage	58,524	17	7
8	Don Pippins							Admin. Wage	12,264	17	8
9	Jacob Alley							Maint. Wage	44,386	6	9
10	Diana Alley							Nursing Wage	11,776	10	10
11											11
12	See Schedule of all Owner Compensation Pg. 24										12
13								TOTAL	\$ 251,539		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna IL 62906
 Phone Number (618) 833-5070 ext. 11
 Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Houskeeping	Mgmt. Fee Contribution	290,400	10	\$ 1,100	\$ 120,000	\$ 455	1
2	5	Utilities	Mgmt. Fee Contribution	290,400	10	2,349	120,000	971	2
3	6	Pest Control	Mgmt. Fee Contribution	290,400	10	55	120,000	23	3
4	6	Maintenance Vehicle	Mgmt. Fee Contribution	290,400	10	196	120,000	81	4
5	6	Maintenance Supplies	Mgmt. Fee Contribution	290,400	10	9	120,000	4	5
6	6	Maintenance Grounds	Mgmt. Fee Contribution	290,400	10	362	120,000	150	6
7	6	Contract Services	Mgmt. Fee Contribution	290,400	10	(111)	120,000	(46)	7
8	6	Repairs Vehicle	Mgmt. Fee Contribution	290,400	10	87	120,000	36	8
9	6	Repairs Building	Mgmt. Fee Contribution	290,400	10	48	120,000	20	9
10	6	Repairs Equipment	Mgmt. Fee Contribution	290,400	10	1,588	120,000	656	10
11	6	Transportation	Mgmt. Fee Contribution	290,400	10	3,193	120,000	1,319	11
12	19	Legal & Accounting	Mgmt. Fee Contribution	290,400	10	3,880	120,000	1,603	12
13	20	Dues, Fees, Subscriptions	Mgmt. Fee Contribution	290,400	10	607	120,000	251	13
14	21	General & Admin. Supplies	Mgmt. Fee Contribution	290,400	10	6,968	120,000	2,879	14
15	21	Postage	Mgmt. Fee Contribution	290,400	10	2,766	120,000	1,143	15
16	21	Software	Mgmt. Fee Contribution	290,400	10	564	120,000	233	16
17	21	General & Admin. Misc.	Mgmt. Fee Contribution	290,400	10	670	120,000	277	17
18	21	Telephone	Mgmt. Fee Contribution	290,400	10	2,839	120,000	1,173	18
19	21	Cell Phone Expense	Mgmt. Fee Contribution	290,400	10	3,106	120,000	1,283	19
20	21	Printing	Mgmt. Fee Contribution	290,400	10	102	120,000	42	20
21	21	Copier Expense	Mgmt. Fee Contribution	290,400	10	790	120,000	326	21
22	22	Payroll Tax Expense	Mgmt. Fee Contribution	290,400	10	17,189	120,000	7,103	22
23	22	Ins. Employee Group	Mgmt. Fee Contribution	290,400	10	30,815	120,000	12,733	23
24	22	Insurance Workmen's Comp.	Mgmt. Fee Contribution	290,400	10	2,304	120,000	952	24
25	TOTALS					\$ 81,476	\$	\$ 33,667	25

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization kel-Tech Management Co.Street Address 158 E. Vienna StreetCity / State / Zip Code Anna IL 62906Phone Number (618) 833-5070 ext. 11Fax Number (618) 833-4993

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	24 Classroom Supplies	Mgmt. Fee Contribution	290,400	10	\$ 618	\$	120,000	\$ 255	1
2	24 Staff Training	Mgmt. Fee Contribution	290,400	10	365		120,000	151	2
3	24 Seminars	Mgmt. Fee Contribution	290,400	10	438		120,000	181	3
4	26 Insurance Vehicle	Mgmt. Fee Contribution	290,400	10	1,046		120,000	432	4
5	26 Insurance Bldg. & Liability	Mgmt. Fee Contribution	290,400	10	1,240		120,000	512	5
6	30 Depreciation	Mgmt. Fee Contribution	290,400	10	12,837		120,000	5,305	6
7	33 Real Estate Taxes	Mgmt. Fee Contribution	290,400	10	1,488		120,000	615	7
8	34 Building Lease	Mgmt. Fee Contribution	290,400	10	7,200		120,000	2,975	8
9	6 Maintenance Wages	Mgmt. Fee Contribution	290,400	10	45,911	45,911	120,000	18,971	9
10	10 Nursing Wages	Mgmt. Fee Contribution	290,400	10	11,776	11,776	120,000	4,866	10
11	17 Admin. Wages	Mgmt. Fee Contribution	290,400	10	70,789	70,789	120,000	29,252	11
12	21 Clerical Wages	Mgmt. Fee Contribution	290,400	10	85,251	85,251	120,000	35,228	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 238,959	\$ 213,727		\$ 98,743	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Ford Motor Credit		X	Van Purchase	\$826.00	8/20/99	\$ 29,744	\$ 5,766	8/20/02	0.9000	\$ 91	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$826.00		\$ 29,744	\$ 5,766			\$ 91	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 29,744	\$ 5,766			\$ 91	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Mulberry Manor**# **0025411** Report Period Beginning: **1/1/01** Ending: **12/31/01****12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$ 23,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 24,116	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 316	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 24,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 24,816	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996 22,627 8		
	1997 22,878 9		
	1998 22,860 10		
	1999 23,131 11		
	2000 24,116 12		
		FOR OHF USE ONLY	
		13 FROM R. E. TAX STATEMENT FOR 2000 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mulberry Manor COUNTY Union

FACILITY IDPH LICENSE NUMBER 0025411

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618)833-5070 ext. 11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-20-03-681</u>	<u>S PT W 1/2 SE S OF RD.</u>	\$ <u>1,352.60</u>	\$ <u>1,352.60</u>
2. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S OF RD.</u>	\$ <u>21,192.10</u>	\$ <u>21,192.10</u>
3. <u>05-20-03-683</u>	<u>S20 T12 R1W S PT W 1/2 SE S OF R1</u>	\$ <u>1,571.10</u>	\$ <u>1,571.10</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>24,115.80</u></u>	\$ <u><u>24,115.80</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

19,715

B. General Construction Type:

Exterior

Brick/Block

Frame

Metal Stud

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Healthcare	76,230	1967	\$ 8,687	1
2	Healthcare	45,000	1976	2,700	2
3	TOTALS	121,230		\$ 11,387	3

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Gazebo		1986		2,561		5			2,561	9
10	Central A/C Units (2)		1988		8,627		10			8,627	10
11	Laundry Room		1990		18,146	576	31.5	454	(122)	6,589	11
12	Landscaping		1990		505	30	15	34	4	390	12
13	Central A/C Units		1990		9,323		10	466	466	9,323	13
14	Improvements to Blue House		1991		4,817	153	31.5	120	(33)	1,563	14
15	Blacktop Driveway		1992		3,260	192	15	163	(29)	2,199	15
16	New Roof		1992		8,055	475	15	403	(72)	5,437	16
17	Remodeled Living Room		1992		1,203	71	15	60	(11)	812	17
18	Seamless Gutters		1993		1,536	91	15	77	(14)	947	18
19	A/C & Heaters		1993		8,823	521	15	441	(80)	5,436	19
20	Dinning Room Improvements		1995		9,127	609	15	456	(153)	3,730	20
21	Bathroom, Carpet & Fencing		1996		4,428	295	15	295		1,622	21
22	Carpet		1997		1,684		7	168	168	1,684	22
23	Smoking Room Addition		1997		46,392	1,189	39	1,160	(29)	4,806	23
24	Smoking Room Equipment		1998		952		7	95	95	952	24
25	Air Conditioner - C Wing		1998		2,446	163	15	163		570	25
26	Kitchen Cabnets		1998		779		7	78	78	779	26
27	Office Air Conditioner		1998		1,059	71	15	71		248	27
28	Storage Building		1999		3,857	257	15	257		642	28
29	Water Garden		2001		2,922	24	15	16	(8)	24	29
30	A/C Compressor		2001		1,027	43	15	46	3	43	30
31	Remodeling		1985		1,867		15	93	93	1,867	31
32	Remodeling-Restrooms		1988		10,790		15	540	540	10,790	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 154,186	\$ 4,760		\$ 5,656	\$ 896	\$ 71,641	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 450	\$ 30	\$ 30			\$ 105	71
72	Current Year Purchases	11,071	11,071	412	(10,659)		11,071	72
73	Fully Depreciated Assets	140,042		11,571	11,571		140,042	73
74								74
75	TOTALS	\$ 151,563	\$ 11,101	\$ 12,013	\$ 912		\$ 151,218	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Ford Van 1993	1993	\$ 25,942	\$	\$		5	\$ 25,942	76
77	Healthcare	Ford Van 1997	1997	25,653	1,723	5,131	3,408	5	24,792	77
78	Healthcare	Ford Van 1999	1999	29,272	2,829	5,854	3,025	5	25,030	78
79										79
80	TOTALS			\$ 80,867	\$ 4,552	\$ 10,985	\$ 6,433		\$ 75,764	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 398,003	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,413	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,654	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,241	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 298,623	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 4,918 Description: Medical Equip. \$4154 / Telephone Equip. \$764

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	91	388		479
3	Classroom Wages (a)	708	3,045		3,753
4	Clinical Wages (b)	1,416	5,989		7,405
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments			4,422	4,422
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 2,215	\$ 9,422	\$ 4,422	\$ 16,059
10	SUM OF line 9, col. 1 and 2 (e)	\$ 11,637			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	21

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 579,095	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	429,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,265,745		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,273,953	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	141,530		15
16	Equipment, at Historical Cost	189,750		16
17	Accumulated Depreciation (book methods)	(242,975)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 88,305	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,362,258	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,928	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	24,907		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	50,295		35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 129,630	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,766		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,766	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 135,396	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,226,862	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,362,258	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,968,653	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,968,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	258,209	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 258,209	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,226,862	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/01

Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,823,704	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,823,704	3
B. Ancillary Revenue			
4	Day Care	739,421	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 739,421	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	132	10
11	Nurses Aide Training Reimbursements	20,881	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,823	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 22,836	23
D. Non-Operating Revenue			
24	Contributions	100	24
25	Interest and Other Investment Income***	12,311	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,411	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Handling Fee Income	138	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 138	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,598,510	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	525,649	31
32	Health Care	1,745,702	32
33	General Administration	426,282	33
B. Capital Expense			
34	Ownership	484,272	34
C. Ancillary Expense			
35	Special Cost Centers	1,250	35
36	Provider Participation Fee	157,146	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,340,301	40
41	Income before Income Taxes (line 30 minus line 40)**	258,209	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 258,209	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number **Mulberry Manor**# **0025411**Report Period Beginning: **1/1/01**Ending: **12/31/01**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,040	2,080	\$ 40,099	\$ 19.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,006	7,330	100,370	13.69	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	27,947	13.44	9
10	Activity Assistants	10,642	10,866	77,797	7.16	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,759	8,855	70,032	7.91	15
16	Dishwashers					16
17	Maintenance Workers	4,018	4,194	42,124	10.04	17
18	Housekeepers	9,642	9,818	81,745	8.33	18
19	Laundry					19
20	Administrator	2,040	2,080	76,800	36.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,271	2,402	23,571	9.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,089	9,249	108,706	11.75	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	66,114	67,342	579,639	8.61	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,621	126,296	\$ 1,228,830 *	\$ 9.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	194	\$ 7,576	1-3	35
36	Medical Director	48	7,200	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	44	1,100	10-3	39
40	Physical Therapy Consultant	16	435	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	82	4,475	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	270	9,645	12-3	45
46	Other(specify)				46
47	Dental Consultant	10	1,100	10-3	47
48	Psychologist Consultant	53	9,300	10-3	48
49	TOTAL (lines 35 - 48)	717	\$ 40,831		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Mulberry Manor

A. Administrative Salaries		Ownership	
Name	Function	%	Amount
Jo Ann Keller	Adm/Owner	50	\$ 76,800
Susan Crews	Clerical		7,634
Linda Isom	Clerical		15,649
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,083

Description	Amount
	\$

C. Professional Services		
Vendor/Payee	Type	Amount
<u>Barnett & Levine</u>	<u>CPA Services</u>	\$ <u>930</u>
<u>kel-Tech Mgmt Co</u>	<u>Management Services</u>	<u>122,719</u>
<u>FMRG</u>	<u>Legal Services</u>	<u>575</u>

[illegible]

D. Employee Benefits and Payroll Taxes	
Description	Amount
Workers' Compensation Insurance	\$ 23,165
Unemployment Compensation Insurance	9,014
FICA Taxes	93,535
Employee Health Insurance	16,884
Employee Meals	773
Illinois Municipal Retirement Fund (IMRF)*	
Misc. Employee Benefits	891
kel-Tech Mgmt Co. Allocations:	
W/C Ins.	952
P/R Tax Expense	7,103
Group Hlth Ins.	12,733
Less: Emp Meals	(773)
Misc. Employee Benefits	(891)

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

[illegible]

TOTAL	\$
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F. Dues, Fees, Subscriptions and Promotions	
Description	Amount
IDPH License Fee	\$ 300
Advertising: Employee Recruitment	2,520
Health Care Worker Background Check (Indicate # of checks performed <u>25</u>)	316
Membership Dues	863
Surety Bond	900
Other Fees	290
Subscriptions	466
Advert. & Contributions	3,084
kel-Tech Allocation	252
Less: Public Relations Expense	()
Non-allowable advertising	(3,084)
Yellow page advertising	()

TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u><u>5,907</u></u>
---	------------------------

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
kel-Tech Mgmt Co allocation:	587
Entertainment Expense	(

Entertainment Expense		()	
	(agree to Sch. V,		
TOTAL	line 24, col. 8)	\$	587

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **Mulberry Manor**

STATE OF ILLINOIS

0025411

Report Period Beginning:

1/1/01

Ending:

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12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 157,146
This amount is to be recorded on line 42 of Schedule V. _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions. _____
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 773 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees. _____

Related Parties Schedule VII
Owners Compensation
Jan 1, 2001 - Dec 31, 2001

	<i>Totals/Entity</i>	<i>Holly Hill</i>	<i>ILS 1-4</i>	<i>JR's Centre</i>	<i>Mulberry Manor</i>	<i>Pilot House</i>	<i>Liberty House</i>	<i>Lincoln Square</i>	<i>kel-Tech Mgmt</i>	<i>Krypton</i>	<i>Glen Brook</i>
Don Pippins	\$ 98,464.24		\$ 12,000.00	\$26,000.00			\$ 6,000.00		\$ 12,264.24	\$42,200.00	
Denise Pippins	103,400.00	36,000.00	21,600.00	45,800.00							
Diana Alley	76,975.72	13,800.00	24,000.00	6,000.00	9,900.00			11,500.00	11,775.72		
Jo Ann Keller	99,600.00			2,000.00	73,600.00	24,000.00					
James K. Keller	15,800.00			2,000.00	13,800.00						
Jacob Alley	44,385.84								44,385.84		
James A. Keller	69,824.00								58,524.00		11,300.00
	<u>\$ 508,449.80</u>	<u>\$ 49,800.00</u>	<u>\$ 57,600.00</u>	<u>\$81,800.00</u>	<u>\$ 97,300.00</u>	<u>\$24,000.00</u>	<u>\$ 6,000.00</u>	<u>\$ 11,500.00</u>	<u>\$126,949.80</u>	<u>\$42,200.00</u>	<u>\$ 11,300.00</u>